WIC/NIH Program
Breastfeeding Partnership Referral Form

(Please use this form to refer women to the WIC Program for breastfeeding peer counselor services)

Patient Information ☐ **RGH** ☐ **HH** ☐ **UNITY** ☐ **SMH**

Last Name_____ First Name, MI _____

Street_____ City_____ Zip_____

Phone # ( ) _____ Alternate Phone # ( ) _____

E-mail _____ Mother's Date of Birth _____

Name of Child: _____ Child's Date of Birth_____

☐ Pregnant – Expected Date of Delivery _____ Gravida_____ Para _____

☐ Nursing – Actual Date of Delivery _____ Multi-Fetal _____

Notes / Special Indications: _____
_____
_____
_____

I authorize the release of the above information to the WIC Program and authorize the WIC Program to release information about me to this health care provider for purposes of coordinating my health care.

Patient Signature_____***Date***_____

Health Care Provider Information

Name (please print) _____ Title_____

Street_____

City_____ Zip _____

Phone # _____

Fax # _____

Date _____

_____
Signature of Health Care Provider

OR completed by BF Peer Counselor (name)_____

Send completed form to one of the following, per patient preference:

Monroe County WIC Program
691 St. Paul Street, 4th Fl, Rochester, NY 14605
Fax # (585) 753-5272 or (585) 753- 5295, **tel.** (585)753-4942
E-mail: wic@monroecounty.gov

Oak Orchard Health- WIC Program
300 West Avenue, Brockport, NY 14420
Fax # (585) 637-4262, **tel.** # 585-637-8809

Jordan HealthLink WIC Program
273 Upper Falls Blvd. Rochester, NY 14605
Fax # (585) 454-2885, **tel.** (585) 454-2630

Finger Lakes SPCC- WIC Program
79 South Main Street, Canandaigua, NY 14424
Fax# (585)394-9285, **tel.** (585)394-9240

PROGRAM USE:

__ NIH Eligible ID # _____ PC Initiation Contact date _____

__ WIC Eligible PC Assigned _____ Ph. # _____ Term. Date_____

This institution is an equal opportunity provider.